Kansas Ryan White Title II C.A.R.E. Program Client Eligiblity Form

Kansas Department of Health and Environment, Ryan White Title II C.A.R.E. Program
109 SW 9th, Suite 605
Topeka, KS 66203
Fax: (785) 291-3420

CLIENT INFORMATION

Name:	**Social Security Number:**
Physical Address:	**Date of Birth:**
City/State/Zip:	**Gender: (Circle One)** Male Female Transgender
Mailing Address:	**Phone Number: (Primary)**
City/State/Zip:	**Phone Number: (Secondary)**

Race/Ethnicity:

- c Caucasian
- c American Indian/Alaskan Native
- c Hispanic
- c African-American
- c Asian/Pacific Islander
- c Language Barrier, Type:
- c Mixed Race, Specify:
- c Not Specified

CURRENT MEDICAL COVERAGE INFORMATION

See attached copy of medical card(s).

Medicaid Benefits:

- c Yes, Attach copy of Medicaid Card Spenddown:
- c No, Attach denial letter from Medicaid agency.
- c Pending, Client is eligible for services for 60 days or until Medicaid eligiblity (whichever comes first).

Healthwave:
(ages <19)

- c Yes, Attach copy of Healthwave Card
- c No, Attach denial letter from Medicaid agency.
- c Pending, Client is eligible for services for 60 days or until eligiblity is determined (whichever comes first).

Medicare Benefits:

- c Yes, Attach copy of Medicare Card
- c No

Indian Health Services:

- c No
- c Yes

Veterans Benefits: **Documentation must be submitted**

- c Enrollee has not served in the United States Armed Forces
- c Enrollee served in the United States Armed Forces

Verified by:

- c Eligible
- c Not Eligible

Other Medical Benefits:

- c Yes, Attach copy of insurance/medical card
- c No

Is enrollee interested in applying for insurance continuation/assistance?

- c Yes, Client MUST apply for Health Insurance Continuation
- c No

INCOME VERIFICATION

See attached proof of income

Annual Family Income:	**Family Size:**

Please attach documentation of income such as pay stubs, copy of social security or unemplyment chech, or copy of most recent income tax return.

PROGRAM REQUIREMENTS

I UNDERSTAND AND AGREE TO THE FOLLOWING:

- The standards for eligibility and participation in this program are the same for everyone regardless of race, color, national origin, age, handicap or sex.
- This program involves the receipt of federal and/or state funds. Any person supplying false information is subject to state and/or federal criminal prosecution, which may result in criminal fines or imprisonment or both. All statements made in this form are true, to the best of my knowledge. I agree to notify the HIV/STD Section if there is any change in my financial situation that would effect my eligiblity for Client Services.
- I hereby grant permission for the Kansas Department of Health and Environment/HIV/STD Section to use my name in discussing this application with my physician, pharmacy, service provider and/or case manager. I understand that my name and/or other identifying characteristics will be released only to those persons authorized to receive the information (KSA 1988 Supp. 65-6001 through 65-6007).

Client Signature:	**Date:**
Case Manager Signature:	**Date:**
Case Manager: (Printed)	**Phone:**